Ricketts (M.)

SURGICAL MELANGE.

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GUT, STRANGULATION, MURPHY BUTTON.—Male, white, age 54, referred by Dr. Reuneker for strangulated left scrotal hernia.

Patient had worn truss for several days with more or less trouble. Consultation occurred forty-eight hours previous. An operation was advised and made at once. Upon opening the sac the intestine was found to be gangrenous to such a degree as to require the removal of six inches thereof. The Murphy Button was inserted and the hernial sac and left testicle were removed. The opening was sutured with silk worm gut, with the lower end of the incision (which was six inches long) left open for drainage.

While the operation was made under the most adverse circumstances, in a tenement at night time and without special preparation, the patient made a rapid recovery, primary union having been secured. The reactive temperature reached 101° and after that time remained normal, there being no difficulty in getting action of the bowels.

The button passed on the 23rd day, and the patient regained his former health.

APPENDICITIS, SUPPURATIVE.—Male, white, age 72, good habits. Was seen at 8 a. m. for the relief of pain in the right iliac region. Had a chill at 5 o'clock on the previous evening, having felt as well as usual up to that time. He had been visited by me six months previous, at which time he had similar symptoms, but not so severe; he was at this time told that appendicitis was the cause of the trouble, but this first attack only lasted a few days, after which he was free from pain. His family recognized progressive debility in him but thought that it was nothing more than the infirmities of declining age.

At the time of the second visit, 8 a. m., September 1st, there was not only great tenderness but severe, constant pain in the appendiceal region. There was no tumefaction whatever. The pulse was full, bounding, and not more that 90. His expression

indicated that he had suffered intensely during the night. The bowels were regular. There had been no narcotic or sedative used during either the first or second attack. Operation was advised and readily consented to. At 2 p. m., twenty-one hours after the chill, an incision was made over the appendix; this organ was found to be bound to the cecum by a band about a quarter of an inch wide. The appendix was 4¼ inches long and greatly distended, and was easily delivered after the adhesions had been broken up. It was then ligated and removed. It contained about 3 teaspoonfuls of white, creamy pus. The stump was cauterized with carbolic acid and returned to the abdominal cavity. The incision was closed with silk worm sutures which were removed at the end of two weeks. The temperature on the following day was 101°, after which it did not exceed 99°. Recovery was rapid and the patient was walking on his lawn at the end of thirty days. The operation was made at his residence in one of the suburbs of the city.

Tubercular Tibia and Fibula.—Male, white, age 21 years, referred by Dr. Lightner, March 8, 1896. There was an extensive ulcer upon lower and external aspect of left leg, considerable in size.

While under the influence of chloroform several inches of the fibula was found diseased. This was removed, leaving the lower and upper ends. The soft exuberant granulations and pus bearing areas were destroyed with curette. At the end of fifty days complete union of the soft parts had almost ensued, and he was sent home with the belief that it would require but a few weeks to make it complete. But he did not do well after reaching his country home, and he was advised to return on October 1st for any treatment that might be necessary.

Chloroform was again administered, and both ends of the fibula were found greatly involved with tuberculosis, and the ankle joint was also plainly involved, all of which necessitated amputation. During the operation the tibia was found to be also diseased, especially the medullary cavity. The fibula was divided within two and a half inches of its upper attachment, while five inches of the tibia was left. The position and great extent of the ulcer made it necessary to utilize the flap to a point below the internal malleolus so that the integument about the inner malleolus

and inner surface of the leg becomes the external surface of the leg. The medullary cavity was cleaned with an irrigating curette. A drainage tube was inserted to make sure of perfect drainage. He was discharged from the hospital on the 20th day after the operation.

HEPATIC ABSCESS.—Mrs. G., age 26 years, housewife, referred by Dr. Beebe.

The symptoms in this case are interesting, in that they resembled those of an acute attack of ordinary lumbago, intense pain being complained of in right hypochondriac and ilio-costal space.

Patient presented marked catarrhal jaundice, slight gastric disturbances, and scant urine of high color.

A swelling the size of a child's head developed at the outer side of the erector spinal mass which soon became boggy and fluctuating to the touch. It was plainly apparent that this mass contained pus or other fluid and it was decided to evacuate the the same.

Under chloroform narcosis an incision about three inches in length was made through the most prominent part of the mass from which about two pints of creamy, bile stained pus flowed. Exploration of the cavity with the finger and probe detected sinuses leading in an upward and forward direction, the terminus of which was not definitely located. From the appearance of the urine and the bile, and the locality of the abscess it was thought highly probable that we had to deal with an hepatic abscess. The examination of the urine and pus disclosed the presence of bile in both fluids, the latter of which contained the greater quantity.

The abscess cavity was curetted and packed with plain gauze.

The discharge from the abscess has been quite copious, necessitating a daily change of dressing.

On the third day following the operation patient had an attack of dysentery, which speedily cleared up on the administration of castor oil and Rochelle salts.

The abscess cavity has become almost obliterated, but continues to discharge about an ounce of pus daily, which evidently comes from the sinus above mentioned. Whether the closure of these sinuses will take place without subsequent operation remains to be seen, although they have diminished in size and length.

EXCISION LEFT ELBOW JOINT.—Miss P., age 21 years, ankylosis following fracture of head of radius, olecranon and coronoid processes, eight weeks previously.

The case was cared for by Dr. Insko, resulting in ankylosis with the arm extended. The pathological specimen showed that no other result could be expected.

A longitudinal incision about five inches long was made posteriorly. The olecranon was removed with the saw as were the heads of the radius and ulna and the lower end of the humerus. The tuberosities being allowed to remain.

It was not necessary to use torsion or ligate any blood vessels.

The wound was sutured and the arm flexed upon a wooden splint, sterilized gauze having been used for packing and general dressing.

LACE HOOK IN TRACHEA; TRACHEOTOMY.—Female, white, age 34 months, brought to my office by Dr. J. W. Clark, who stated that the child had swallowed a lace hook forty-eight hours previously.

The child's condition was alarming; it at times almost suffocating.

A consultation was at once had and an examination made by Dr. Kramer, who by means of the fluoroscope discovered that the foreign body was located in the trachea on a level with the clavicle. It was decided to make a low tracheotomy, but it was deemed best to await the advantages of daylight, after precautions had been taken to prepare for operation at any time during the night, should the same become necessary.

On the following morning chloroform was administered and a low tracheotomy made. A probe was introduced into the trachea above the incision, but the body could not be detected. The probe was then introduced downward without finding the body. The child was then taken by the ankles and shaken head downwards for several minutes. An examination was again made above the incision and the lace hook was detected at the upper end of the incision in the trachea.

It was firmly wedged transversely in the trachea and a considerable amount of force was required to extract it. The incision was not sutured, but left open with a long piece of silkworm gut on each side of the trachea that it might be quickly opened at

any time. A piece of gauze was strapped over the opening to prevent foreign bodies from getting into it. The wound was left to close by nature.

The child made an uninterrupted recovery and left the Trinidad on the twelfth day following the operation, but could have left a week sooner had it not been that her infant brother took pneumonia as the result of exposure on the trip to the city.

EXCISION OF THE HEAD OF THE HUMERUS.—Mr. P., age 46 years, referred by Dr. Gillette. Fell from a ladder a distance of ten feet, striking his left shoulder on the pavement and sustaining dislocation of same, complicated with fracture of the base of the surgical neck.

Under chloroform narcosis reduction was easily secured, but the fragments could not be kept in apposition and after several unsuccessful attempts it was deemed advisable (as there was not much probability of securing a useful limb by ordinary means of treatment), to resort to procedures more radical.

The patient was brought to the hospital on the following morning and it was decided to reset the head of the bone which was done.

Assisted by Drs. Gillette and Layne, an incision beginning at the outer third of the clavicle carried down over the acromion process in the direction of the fibres of the deltoid muscle was made and the fibres of the muscles were separated by blunt forceps down to the capsule of the joint; this was opened and the head of the humerus found lying beneath the coracoid process of the scapula. It was yet thought possible that a reduction of the head of the humerus might be secured and an endeavor was made to reduce it by means of a strong hook after perforating with a drill.

It proved, however, to be too fragile, breaking on slight traction, and this hope was abandoned. It was then removed and the lower fragment which was comminuted was removed by Wyeth's saw. The wound cavity was then dried out and tightly stuffed with gauze, which was allowed to hang from the lower end for drainage. The skin and fibre of the deltoid were then approximated by ten interrupted silkworm gut sutures and the wound dressed with plain gauze. The arm was then bandaged to the side, the forearm being supported by a sling in order that the use of the elbow might act as traction to overcome the opposing

muscles. The gauze was removed 24 hours after the operation and wound redressed. Primary union was secured and the sutures removed on the seventh day, patient leaving hospital on 11th day.

Barring a slight stitch abscess no untoward symptoms occurred to mar speedy recovery.

It is fair to believe that this method of treatment offered the patient the best chance for a useful arm, but what the ultimate result will be time must decide.

AMPUTATION.—Mr. H., age 58 years, German. Large plethoric habitus. While on shipboard en route from Germany to America was taken with pain in right leg. This was rapidly followed by swelling and discoloration of toes and dorsum of foot which soon presented a gangrenous appearance. At the time the vessel reached N. Y. harbor his condition became so alarming that he was taken to the hospital, from which place he was rapidly transferred to Newport, Ky., the home of his relatives.

He was then seen and presented the following conditions: Right leg gangrenous as far up as the upper fourth of the leg, portions of the foot and ankle having begun to slough; patient's general physical condition exceedingly bad. Immediate amputation advised as the only chance to save life. On the evening of same day he entered the hospital and the lower fourth of the femur was amputated. During the administration of the anesthetic the patient collapsed and was only revived after considerable difficulty, but rallied sufficiently to permit completion of operation. The patient was placed in bed, salines administered and hot water bottles applied to the surface of the body. Shock was not profound, but patient never rallied sufficiently to be perfectly conscious of his surroundings. Later attempts at stimulation by means of strychnia, nitro-glycerine, whisky, &c., failed to rouse the flagging pulse, and the patient expired on the following morning, eleven hours after operation. The peculiar feature of the case is that powerful stimulants failed to have the slightest effect upon the weakened heart. Never once did it show the slightest reaction to stimulation which would ordinarily cause prompt response. The condition of the arteries throughout the body was that of arterio-sclerosis,, and it is highly probable that embolism of the popliteal artery was the cause of the gangrene. Correct diagnosis was guessed at previous to the operation.

Amputation Middle Thigh for Compound Comminuted Fracture Middle Third of Right Leg.—Case, age twenty-eight years, white. Called to see the case with Drs. Wells and Chandler, June 10, 1896. The fracture had occurred on November 4, 1894. Union could not be secured; a small spicula of bone being thrown off now and then.

A bone ring from the tibia of a bullock was applied with most excellent results, so far as holding the ends of the bone in close juxta position.

Although much bony tissue was formed about the ends of each fragment, failure to become united seemed absolute.

Amputation at the knee joint was decided upon and attempted on the day of my visit. Upon opening the joint the condition of both the bony and soft tissues was such as to cause an attempt to sacrifice but the condyles. This, too, proved fruitless, so that it was necessary to amputate at the middle third. Recovery was rapid with a most satisfactory stump for such a locality.